THE MEDICAL COLLEGE OF GEORGIA
The Health Sciences University of the State of Georgia

TODAY

Summer 1989 Volume 18, Number 1

Community Outreach

Stretching the Boundaries of Our Care

Introduction

So much material, so little space. . .

It's a universal editor's dilemma and one which presented itself in spades for this community outreach edition of *Medical College of Georgia Today.* When story suggestions for the magazine were solicited from MCG deans and department chairmen, the response was overwhelming. Practically everyone asked had not one, but a dozen or so examples of their school's or department's altruism.

For those who ever doubted MCG's commitment to the community, be assured that the care and compassion of its students, faculty, staff and alumni are felt at every level of society.

For instance, this issue features two student groups—Doctors Ought to Care and Students for Community Involvement—whose members deliver rousing, good-natured lectures to schoolchildren about the importance of healthy lifestyles.

Also featured is an Augusta organization offering support and information to people with AIDS. Its president is an MCG staff member, its educational coordinator an Allied Health Sciences faculty member.

And School of Dentistry alumna Alda Underwood is highlighted. She's offered her services to Atlanta's most impoverished and downtrodden residents.

Many community efforts pool the resources of MCG's staff and students. Featured in this issue is MCG's Children and Youth Project, which offers health care to residents of Augusta's low-income housing projects. The project also provides training and research opportunities for students.

As you read these and other articles in this edition of the magazine, consider that these people and projects represent only the tip of the outreach iceberg. MCG's many community efforts didn't all find their way into the pages of the magazine, but be assured their effect is felt daily by some segment of the community.

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USPS 867340 Summer 1989, Volume 18, Number 1

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The Medical College of Georgia is the health sciences university of the University System of Georgia. Focusing on health care education, research and patient care, the Augusta-based institution consists of MCG Hospital, more than 80 support clinics, statewide outreach programs and the Schools of Allied Health Sciences, Dentistry, Graduate Studies, Medicine and Nursing.

Medical College of Georgia Today (USPS) is sponsored by grants from MCG Foundation Inc. and produced by the Division of Institutional Relations, Medical College of Georgia, Augusta, Georgia 30912. Published quarterly, it is furnished to alumni and friends of MCG without charge. Second-class postage is paid at Augusta, GA.

A Helping of Health Care

The waiting rooms resemble those of any other pediatric health care facility. Mothers browse through magazines or chat with others in the room, keeping watchful eyes on their children and occasionally admonishing them for getting into something they shouldn't. The children mill around, sometimes bored, sometimes nervous about what awaits them in the physician's or dentist's office.

Inside those offices, the health care professionals commence with a normal day's work. The dentist fills cavities, dispenses advice about brushing and avoiding snacks, gives the patient a new toothbrush for good measure... The physician gives checkups, tends to tummy aches or sore throats, confers with mothers about their children's health...

So what sets these facilities apart from others? Basically, just one thing: did they not exist, their patients likely would go through childhood and adolescence with negligible or non-existent health care.

The facilities comprise the Children and Youth Project at the Medical College of Georgia. Included in the operation are two neighboring trailers on campus: one for medical care, the other for dental care. They opened in 1966, funded by a federal grant and designed to offer health care to children living in six of Augusta's housing authority projects. Residents of a seventh Augusta housing project have since been included in the project.

"The project started out as a five-year demonstration to study the impact of comprehensive health care for children who didn't otherwise have ready access to it," said Dr. Charles Linder, medical director of the project. Dr. Linder, who joined the clinic in 1971, also is a professor of pediatrics, associate dean of the MCG School of Medicine and chief of staff at the MCG Hospital and Clinics.

The project uncovered a huge need for the services. Before the clinics opened, the children either went without proper health care or had their needs tended to in hospital emergency rooms.

"Without us, they would get sporadic care on an as-needed basis," said Dr. Robert H. DuRant, project director and assistant professor of pediatrics.

Once the federal grant expired, Georgia's Department of Human Resources took over through a federally funded block grant and has funded the project ever since. It is the only such project in the state and one of about 65 in the United States, according to Dr. Linder. This year's budget is $477,700; the dental clinic's budget is $25,000.

The project offers 24-hour-a-day comprehensive health care to those age 19 and younger. Its 24 staff members include three physicians, two dentists, dental hygienists, nurses, nutritionists, social workers, a social psychologist, community health workers and administrative personnel. Those requiring hospitalization are referred to the MCG Hospital and Clinics. If space is available, the services also are extended to low-income families who don't live in the housing projects. The medical clinic also provides care for adolescent females in the Department of Human Resources' group home in Evans for teens with severe emotional disorders.

About 40 patients attend the medical clinic daily (about 2,200 a year) and about 25 attend the dental clinic daily. Dr. Linder estimates that 95 percent of those for whom the services are available take advantage of them.

"My perception is the program has been very much appreciated by the community," he said.

The patients' parents echo the senti-

Dr. Carolyn Seymour examines patient.

ments. "I've been taking my grandchildren here since I moved to Gilbert Manor (an Augusta housing project) not long ago," said Louise Pickens, whose grandchildren are ages six weeks to 8 years. "I'm so glad it's here for us."

And the clinic addresses more than just its patients' health care needs. The staff meets with a community advisory board twice a year and discusses the problems faced by low-income families. The staff either tackles the problems itself or matches community members with the resources necessary to improve a situation. For instance, the group has helped get apartments repainted with lead-free paint. It also has facilitated insect extermination and replacement of torn window screens.

The staff also tackles problems with less clear-cut solutions. Substance abuse, family discord and teen pregnancy are common among the patient population. Staff members keep an eye out for such problems and offer assistance in various ways. For instance, peer counselors were hired at one point to counsel teen patients and help them avoid unwanted pregnancy. The staff members themselves often discuss the price of unhealthy lifestyle choices with their patients.

"There's some counseling in just about every patient encounter I have," said Dr. Robert A. Pendergrast, assistant professor of pediatrics and director of adolescent health services at the clinic. His patients are age 11 to 19. "We try at all times to keep parents involved with the kids, but we also try to ensure the kids of confidentiality. Otherwise, they tend to postpone medical care."

Along with dealing with the consequences of unhealthy lifestyle choices, Dr. Pendergrast also tries to head them off. For instance, one of his pre-teen patients recently was coming in frequently complaining of headaches and fatigue—symptoms often indicative of emotional distress.

"I talked to her and her mom and found out the kids at school have been picking on her for five years. She has a terrible self-image," Dr. Pendergrast said. "She's overweight and she overeats to compensate for her emotional needs that aren't being met. She's begun to believe that she really is as worthless as everybody tells her she is."

Dr. Pendergrast now can address the root of the problem and try to correct it before the patient perhaps resorts to antisocial behavior to deal with her unhappiness.

"I put myself fairly personally into these kids' problems and try to feel what they feel," he said. "An adolescent knows when you really don't care. I want to help them take control, as they grow into adults, of their own health destinies. They can really take control of their own lives, and that's a message many of them have never heard before."

"We don't try to force our standards on them," Dr. Linder said. "We just want to keep them informed. I think education is one of the strongest components of the program."

Of course, the staff members spend the majority of their time addressing the more routine aspects of pediatric and

A Helping of Health Care

adolescent care, such as immunization and checkups. Most of the patients are quite healthy, despite a steady stream of those with dental or nutritional problems.

"Most of these children have an adequate diet, calorie-wise," Dr. Linder said. "They just don't eat the right balance." Iron deficiences, for example, are common.

Dr. Karen Pierce, assistant professor of community dentistry and supervisor of the Children and Youth/Augusta Dental Project dental clinic, provides her patients with comprehensive dental care. She also encourages them to practice good oral health care but noted that her patients are quite knowledgeable about it.

"I think the patient population has become more educated about dental health care," she said. Many are children of the first generation to benefit from the clinic and their understanding of health care is a testimony to the aid their parents reaped from the program, she said.

The dental clinic also receives a $104,000-a-year state grant that supplements the Children and Youth grant and allows the staff to extend its care to all low-income Richmond County residents—not just those living in housing projects.

"We're on a limited budget, but we're trying to encompass as wide an area as possible," Dr. Pierce said. "That's one of the reasons we are now providing care for children, adolescents and high-risk pregnant women in Richmond County as well as surrounding counties in the east central health district."

Community members aren't the only beneficiaries of the Children and Youth Project. MCG students and residents train in the clinics.

"The patient care gives us the opportunity for excellent teaching experiences," Dr. Linder said. "It's also been the source of much research."

Dr. DuRant devotes about a third of his time to such research, which has included teen contraceptive compliance and reduction of cardiovascular disease risk factors among children and adolescents.

"When you combine research with patient care, you're really offering better patient care to the community," he said.

"The trick for us," Dr. Pendergrast said, "is to make sure the patients get the best quality care at the same time that I'm trying to teach residents and students how to give that care. It's not so much a problem as a challenge."

Is the clinic up to the challenge?

"I think the fact that we've been funded for 22 years is testimony to the program's success," Dr. Linder said. ■

—Christine Hurley Deriso

Nurse Renee Harris measures patient's height.

Icing on the Cake

In Georgia, about 13 of every 1,000 babies born alive don't live to play in the icing on their first birthday cakes.

That's the fourth-highest infant mortality rate among the 50 states.

In rural Jefferson County, Ga., about 70 miles southeast of the Medical College of Georgia's home in Augusta, the infant mortality rate is nearly double the state's—about 22 of every 1,000 babies from that county who are born alive don't make it to their first birthday.

A project directed by the MCG School of Nursing and funded by MCG and a three-year grant from the W.K. Kellogg Foundation of Battle Creek, Mich., is aimed at changing those statistics in Jefferson County. And it is hoped the project also will be successful in other rural areas of the state and nation.

Although the project is still in its initial stages, the statistics compiled by grant workers already confirm the grim realities of the infant mortality problem.

Of the four Jefferson County babies born at MCG since the project began in September, the first very premature infant died; the second infant was premature, but after a lengthy hospital stay was discharged; the third baby was healthy; and the fourth baby was stillborn.

One healthy, one sick and two dead.

"That's a pretty good indication of what's going on there," said Dr. Janet Hardy Boettcher, assistant professor in the Department of Parent-Child Nursing and coordinator of the MCG Rural Outreach Program.

"Right now, the families just stop showing up at the health departments," Dr. Boettcher said. "We need to find out why they stop, analyze the trends, and see, after six months, who has babies who have gotten sick or died, and who has well babies. Then maybe we'll know what the problems are.

"We've got to help people earlier, before they get here," she said. "We can't wait until it's time for the baby to go home to find out that there are problems getting the baby food or something else."

For that reason, the Kellogg grant money, which at $795,697 is the largest private grant in the School of Nursing's 46-year history, is being used to begin a Jefferson County community outreach program to teach prenatal and infant

care and direct mothers to health care services. A community projects coordinator will be responsible for those projects.

Also, health committees will be established in area churches and clubs to develop strategies to improve parent-child health and reduce infant death and illness.

Two nurses also will work in the county in a mobile health unit, which began operating in July. The unit, which was built especially for this project, offers prompt health care to parents and children in medically underserved rural areas.

"It's been like building a house, from the circuits and plugs on up," Dr. Boettcher said. "But because it's specifically designed for what we need, we've been able to start up right away."

A social worker also will work on the mobile unit and will spend time in the schools working with health educators. The social worker has just begun working with the prenatal team of the Jefferson County Health Department.

And finally, a computer system now being established will link the cases of high-risk newborns to appropriate follow-up facilities. When operational, the computer tracking system will follow a Jefferson County infant from prenatal care to birth to follow-up exams.

It's that type of communication—linking one health care provider to another—that has proven to be an important part of the outreach program's initial stages, Dr. Boettcher said.

"For example, the hospital representatives thought the county health nurses were making routine neonate health visits, when actually, they haven't been able to do that for a few years because of staffing problems," Dr. Boettcher said.

Ultimately, the computer also will provide a valuable communication link, as other hospitals could access the information gathered about mothers and infants in Jefferson County.

And the project is geared to continue operating in Jefferson County even after the three-year grant money is gone. That future of the project is particularly pleasing to Vicki Sherrod, who is working as the data manager for the project's computer system.

"If this project can help one person, that makes it all worthwhile. But the future aspect of this project is that it could go from place to place, from county to county, and deal with the problems there," she said.

It is possible that the project could be applied throughout rural areas of the South. Of the 12 states with the highest rates of infant death, 10 are in the South, according to a report issued by the National Commission to Prevent Infant Mortality.

—Stephanie Neal

A Dream

Dr. Alda Underwood was 13 when she witnessed Dr. Martin Luther King Jr.'s compelling speech at the civil rights march in Washington.

And from Newsome Park, a Virginia housing project, she had dreams of her own. A dream of going to college and becoming a nurse. And a dream of instilling hope in kids like herself.

In 1972, Dr. Underwood graduated with a nursing degree from Hampton Institute, a small, private, traditionally black college in Virginia. In 1977, she earned a master of science degree in nursing at Emory University in Atlanta.

"I was a nurse, and a very good nurse, for ten years," Dr. Underwood said. She worked as an intensive care nurse, a coronary care nurse and ran a hypertension clinic for Emory. The clinic was part of a national study and when the study ended, so did her job.

After the clinic closed, she underwent jaw surgery. Being a nurse, she wanted to understand every aspect of the process, she said.

Through the dental surgery process, she found a new dream. And in 1984, she graduated from the Medical College of Georgia as a doctor of dental medicine.

When Dr. Underwood went to dental school, she was three months shy of 30 years old and had been to a dentist three times in her life.

"It's a matter of what happens when you're growing up," she said. "When I lived in the project, the only time you went to the dentist was when you needed to have a tooth pulled."

So when Dr. Underwood graduated from MCG, she moved back to Atlanta and opened an inner-city dental clinic on Simpson Street to offer her services to the urban black community. And to offer them hope.

"You always have to give something back to the community," she said. "You can't always be the recipient; you have to be a giver, too."

Dr. Underwood concentrated on the children. She once took 15 children on a trip to Six Flags. She took them to White Water, an Atlanta water park, and roller skating. And she held informal meetings where kids could talk about sex, birth control and drugs, and where she advised them about how to deal with peer pressure.

"The most important thing I gave to those kids was (the belief) that you could be something," she said. "The trips to Six Flags, White Water and roller skating were so they could trust me. They have to be special to somebody and they feel that they're important to me.

"I believe that part of my mission was to give them hope," she said. "Without a

"I have a dream that my four little children will one day live in a nation where they will not be judged by the color of their skin, but by the content of their character."

Dr. Martin Luther King Jr.
Washington, D.C., Aug. 28, 1963

Come True

dream, they can never get out (of their situation)."

Dr. Underwood understands why many of these children don't have high aspirations.

"People have perceptions about what urban poor blacks are like," she said, referring to the image of people on welfare who own color televisions and Cadillacs.

"You have to realize that there's a reason for that. That's what they perceive as the American dream. They can't even envision our American dream of a four-bedroom house in the suburbs," she said. "The only piece of it that they can attain are the color TV and a Cadillac."

Dr. Underwood made concessions when it came to collecting money from her patients. Sometimes they did other things for her, like washing her car. But most often, Dr. Underwood's payment was the sense that she had helped someone else.

"We can't hold them to the same standards we hold on other patients," she said. "You don't view them as being a ditcher, you have to think of them as a patient. You have to understand them as human beings.

"Many of my patients lived in section-eight housing, on food stamps, wearing hand-me-down clothes," she said. "Can you imagine someone coming in and needing an $800 denture? That's more than they get from welfare in a month."

She understands why generations of urban families continue to live on welfare in slums. She befriended a 13-year-old girl whose mother had nine children by the time she was 25.

"For them, welfare means a check because a job isn't a possibility," she said. "Four dollars an hour can't support you. You have to take child care and insurance out. That makes $300 a month seem like a good amount of money and having a baby means $90 a month more."

Many of her patients didn't care for their teeth. To some, a toothbrush was an extravagance.

"I gave toothbrushes away and the kids would come just to get one."

Dr. Underwood is in a period of transition now. The building downtown has been torn down and she's building a practice in Decatur, a suburb of Atlanta. Some of her former patients still come to see her, even though it takes two buses and a train to get to her temporary office.

While she practiced downtown, Dr. Underwood gave those inner-city children a lot more than toothbrushes. She gave them hope.

"If I could just make one of these children become better than they ever thought they could, then everything I did on Simpson Street was worth it," she said. ■

—Karin G. Calloway

Picture for a moment the immaculate, antiseptic, starchy-white environment of a dentist's office. Now consider the grimmer, grayer world of poverty.

What do the two worlds have in common? For one thing, Medical College of Georgia School of Dentistry students are equally at home in either environment, thanks to the school's community dentistry course.

The course dates back to 1970. Dr. J. Earl Williams, chairman of the Department of Community Dentistry, joined the MCG faculty in 1969. He was a man with a mission. He wanted students to approach the profession with altruism and awareness of community needs. Since those most in need of dental services—the poor, the elderly, the mentally handicapped—generally are those least likely to walk into a dentist's office with cash in hand, Dr. Williams envisioned graduates willing to take their services to the needy.

Twenty years later, he beams with pride in the students who have transformed that vision into a reality.

"One of our graduates recently called and said he's a dental consultant for a nursing home," Dr. Williams said. "That's the payoff."

The community dentistry program consists of six three-day courses. The students are trained for a community mission at the beginning of each course and spend the remainder delivering the service. The courses also include lectures and laboratory experiences.

"I asked the administration in 1971 to allow us to structure our courses like a continuing-education class," Dr. Williams said. "It's been very successful."

It's also been quite a challenge for course instructors Dr. Williams and Dr. Karen Pierce, assistant professor of community dentistry.

"The preparation for these courses is extensive. It requires a lot of planning and scheduling. I can't remember having taught the same material in the same way two years in a row. There are constant changes in the profession," Dr. Williams said.

But he wouldn't have things any other way. "This work is fascinating," he said. "I wouldn't trade places with anybody. I like helping students discover that people are important, regardless of their circumstances. That really turns me on. We in dentistry have a wonderful opportunity to help people realize their self-worth."

The students begin the program the first quarter of their freshman year by visiting local dentists and discussing the profession in general and problems unique to low-income dental patients in particular.

"For the first time for many of these students, they're talking with a dentist as a colleague instead of as a patient," Dr. Williams said.

The students then travel to low-income areas of the community. Accompanied by a dental school faculty member and a social worker, they meet with a family, screen both parents and children for dental problems and discuss their dental needs.

"We try to convey to the students the population's needs and struggles," Dr. Williams said. "The thing that comes through loud and clear for our students is the parents' concern for their children's health. It's important for our middle-class students to know this."

During spring quarter of their freshman year, the dental students visit a Richmond County elementary school with a high percentage of students from low-income families. They screen the third- through seventh-graders for cavities, gum disease and oral hygiene in general. Five to six dental faculty accompany the students and confer with them about any problems they spot.

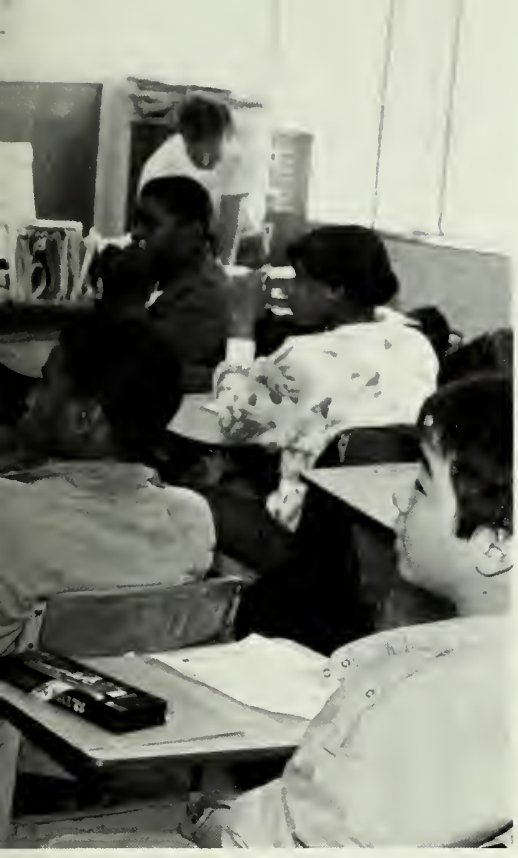
"Because of fluoridation (in the drinking water), the children we see are basically in good shape," Dr. Williams said. "It's amazing to remember what it was like before fluoridation. The children would have abscesses, broken-down teeth—they'd just in in awful condition."

Now, about 35 percent of the children they screen have no cavities. "When we do find needs among the children, we refer them to their dentist or the health department or (MCG's) Children and Youth Dental Clinic," Dr. Williams said. "The students also teach them how to brush and care for their teeth. They discuss good eating habits and give them toothbrushes. What we don't want to do is go in and just utilize a population for our benefit. We want the students to learn, of course, but we also want to leave the schoolchildren better than we found them."

Dr. Williams also insists that the children be treated courteously. "We try to work with them in a very respectful way," he said. "We don't embarrass children or make examples of them. We try to be very discreet." They are screened one at a time and don't have to participate if they choose not to.

The dental students cooperate beauti-

Service with a Smile



Students learn flossing techniques.

fully, he said. "The students always perform admirably. I'm impressed yearly by how well they conduct themselves."

Another facet of the program sends the students to the Children and Youth Dental Clinic, which serves children from low-income families. The students, again under faculty supervision, apply sealants to the children's teeth. Sealants harden into tooth cracks and help prevent decay. About 80 percent of decay begins in these cracks when they are left exposed.

"This course gives students the public health perspective of dental disease, and it makes their first clinical experience a preventive experience," Dr. Williams said.

During the students' seventh quarter of dental school, they visit a local nursing home and center for the mentally retarded. Before the visits, students watch videotapes and listen to personal accounts of the lifestyles of the centers' residents. They also acquaint themselves with the backgrounds and interests of the nursing home residents before meeting them.

"This helps them realize (the nursing home residents) were real-live contributing folks before they became dependent," Dr. Williams said. 'It's a tremendous opportunity for the students to see the interplay of social, dental and medical factors and to learn that these are people fully deserving of all our respect."

The same is true of the mentally handicapped, he said. "The mentally ill are so scary to some people," Dr. Williams said, noting that the dental students are much more comfortable around them after the course.

The community dentistry program also coordinates summer public-health clerkships for rising seniors. The students go to medically underserved sites worldwide, including Indian reservations and centers for the mentally ill. Last summer, students visited such sites as Australia, London, Ireland and Israel. They stay three to four weeks and offer dental services under the supervision of a licensed dentist. They aren't paid but receive class credit for their work.

The program culminates with an ethics course for seniors, which alerts students to potential pitfalls associated with the stress of the dentistry profession.

"Some of the things that make us good dentists also lead to unusual stress," Dr. Williams said. "For instance, we tend to be perfectionists, which is good if it's kept in perspective. We have to balance the desire to be perfect with the need to be effective and efficient and just do the best we can. We don't want to alarm students—we just want them to be alert to potential stressors."

Dr. Williams and guest lecturers discuss alcoholism, drug abuse and other manifestations of stress during the course. He and Dr. Pierce also conduct workshops in which students act out stressful situations or ethical dilemmas they may encounter on the job. The faculty advise them about appropriate ways to handle the situations.

"We have to discuss ethics," Dr. Williams said. "Without ethics, we're not a profession."

Dr. Williams can't promise that dental students will be better people as a result of the community dentistry program, but he's confident that they leave school better informed about community needs than they were when they began. And perhaps more importantly, the community is better informed about the dental school, having witnessed its students' help and compassion first-hand.

"If we can show people we care about them," Dr. Williams said, "that's way more than half the battle." ■

—Christine Hurley Deriso

The Heart of the Matter

The Joseph Stephen Bowen family is one of more than 100 Richmond County families that have opened their homes and hearts to science.

Three years ago, first-grader Lacey Dianne Bowen was one of 24,000 children to bring home a family health history survey.

The family of four was one of 15,000 families to return the family histories.

Lacey's younger brother, Stephen Michael Bowen, pegged the Bowen family as one of 700 families from that group with a 3- or 4-year-old child.

A further weeding to pick the 50 families at highest and lowest risk of cardiovascular disease based on family histories put the Bowen family in a landmark research effort at the Medical College of Georgia.

"The National Heart, Lung and Blood Institute put out a request for proposals," said Dr. William B. Strong, Charbonnier professor, chief of the Section of Pediatric Cardiology and principal investigator on the $1.2 million, five-year grant.

"They wanted to see if we could determine how children, beginning at 3 and 4 years of age, learn their behaviors of nutrition, physical activity and some of their psychological characteristics . . . how they learn their type A behaviors basically."

The hypothesis is that these lifestyles and attitudes are learned early. "Now, whether they can be modified is another question," he said.

The major implication is that if these habits are learned at such tender ages, effective intervention also must start very early.

Research assistants go into the homes of these families, talking to members about what they eat, when they eat and if they exercise. Family members are weighed and skin-fold measurements are taken.

Youngsters such as Stephen then are brought to the MCG campus for yearly treadmill studies to see how the cardiovascular system responds to use.

Stephen, who wants to be a fighter-pilot, fire-truck-driving doctor, seems to be the most active of his family. "I like to chop wood and I like to ride my bike," volunteered Stephen, now age 7. He doesn't love school. "All we get to do is sit on our seats and do work."

Commented his father, "There are two things he likes about school: recess and getting out. But he makes A's."

Sister Lacey would rather read and watch television. Her mother is inclined to do the same, but Paula Bowen encourages her daughter to get out more and she is making an effort to exercise regularly.

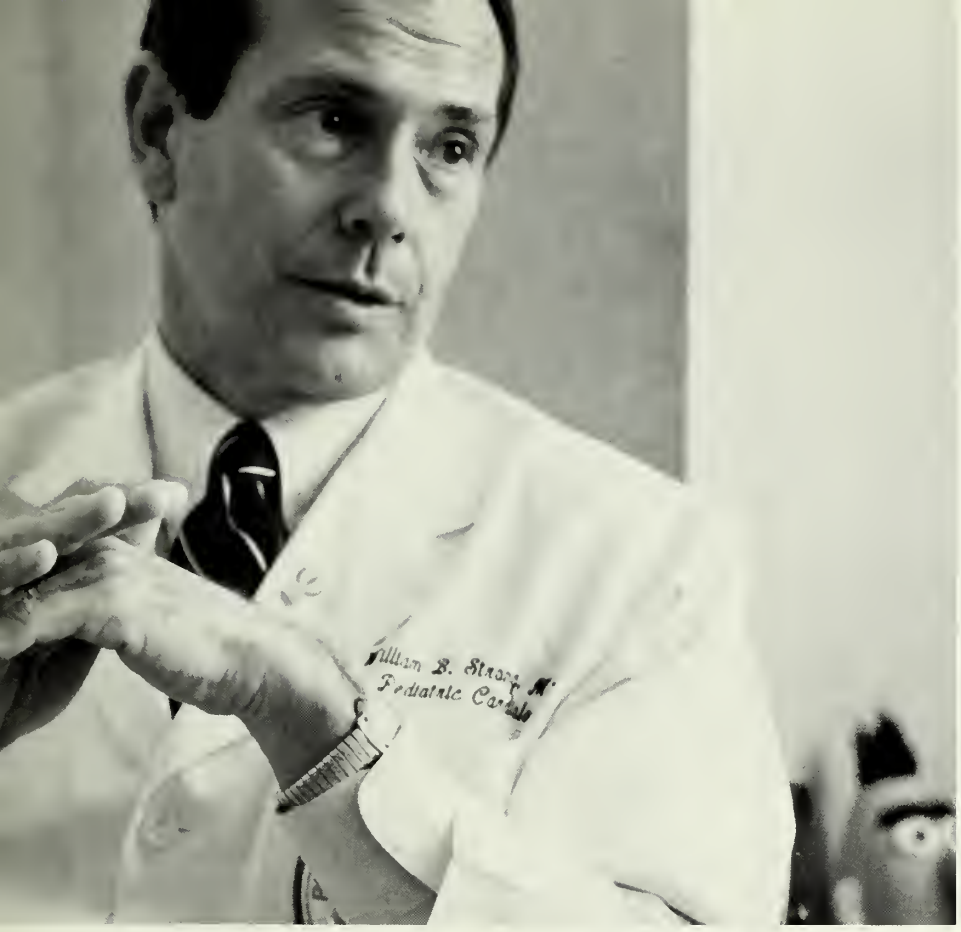
The youngest Bowen also is a confessed muncher, who prefers slices of American cheese and sweets to any meal you sit down to. "As far as trying to get him to eat a well-balanced meal, it's a struggle," Mrs. Bowen said.

The rest of the family has a pretty hearty appetite. "My problem is there is not really a way I don't like (food), except for spinach. I'm not crazy about it, but I will eat it," said the truck-driving father who, by necessity, eats many of his meals on the road.

Mrs. Bowen loves sweets, a trait she apparently passed on to Stephen. Everyone admits to a love for fried foods, although Mrs. Bowen is making an effort to bake and broil more. French fries are a family favorite, but brussel sprouts, broccoli and cauliflower also are regularly on the menu.

The parents have a history littered with cardiovascular disease. Mr. Bowen said virtually everyone—men and women—in his family has had some type of cardiovascular problem. His father died of a heart attack at age 65 and his mother has angina.

Mrs. Bowen's father died from amyotrophic lateral sclerosis, but he also was



Dr. William B. Strong

a three-pack-a-day smoker who had a heart attack at age 40.

Mrs. Bowen started smoking when she was 17, but gave up the habit more than a year ago at the request of her two children. "I knew all the facts about how bad it was for you. The problem was, I actually like smoking. I enjoyed it."

Mr. Bowen, who has been smoking probably two packs per day for a quarter of a century, is a harder sell. He's thought about quitting, but he knows himself well enough to know that he may as well not bother to try until he's really ready to quit. He is not yet ready.

But both parents hope the children will never pick up a cigarette.

By sharing these habits and lifestyles, this young family and hundreds more participating at MCG and seven other institutions are helping researchers gather essential data that can change the health course of the future.

The idea is to follow the young children for five years initially and, hopefully, through adolescence to determine if unhealthy lifestyles are learned early on—preliminary data suggests that they are—and to see if living in a more healthy manner really does make a difference.

"If children can be taught, if they can learn the appropriate, prudent lifestyles of sufficient physical activity, the psychological aspects (and) non-smoking . . . then we will end up with an adult population that is more physically active, therefore cardiovascularly healthy, which will be leaner, which is good for diabetes, which is good for stroke, which is good for hypertension, which is good for many factors," Dr. Strong said. "You work on the smoking and get rid of the lung disease that also is involved. So you can have a major impact on really giving a higher quality of life to the population as a whole.

"(The study) is aimed at this point at cardiovascular disease, but there is a much broader picture of the spin-off of these other chronic illnesses," he said.

And the effort to collect needed data is exciting, endless and already bearing some fascinating results.

When the study was just beginning, it yielded some interesting findings that would alter the study itself.

"We had it initially set up that we were only going to do two-parent families . . . and we would only go into the home when mom and dad were eating supper with the child," Dr. Strong said. "We had to change the design of the project since mom and dad very rarely had meals together. Dad is out, or mom is out. When you talk about the home situation, you've got 60 percent of mothers with young children in the work force. That means you've got 60 percent of children probably in some form of day care. So the family no longer is as relevant as we think it used to be. Nobody had done these measurements before. So we had this idea of an Ozzie and Harriett family that does not exist anymore."

Pilot studies for the project also yielded interesting data. Looking at two groups of 7- to 10-year-olds—one group active, the other not—active children already proved to be leaner, have lower blood pressures and do better on exercise testing.

The difference in these children is not some structured exercise program, just a difference of being an active child who takes the stairs and plays in the back yard instead of being a "couch potato," Dr. Strong said.

Pilot studies also compared 10-year-old white children and 10-year-old black children who were exercised to their maximum capacity. Researchers found that although the blood pressures of the two groups of children remained about the same, their cardiac outputs were different.

The blacks seem more efficient, able to do the same amount of exercise with less cardiac output, Dr. Strong said. But the study also indicated that the blood vessel tone is tighter in the blacks. That area is being explored in a separate grant recently obtained by Dr. Frank A. Treiber, child psychologist and assistant professor in the Departments of Pediatrics and Psychiatry and Health Behavior.

Preliminary information on the 1985 grant already is showing distinct differences between the 50 high-risk and 50 low-risk families. Low-risk families eat better, consuming less cholesterol, saturated fats and calories.

Data has yet to be analyzed on physical activity trends, although it does appear that the father's physical activity has little to do with the physical activity of the child. "At this early age, if the mother is physically active, that does have an impact," Dr. Strong said.

"It's interesting. When you break this down, the mother's impact is only on the weekends if she works outside the

home. The mother who does not work outside the home only has an impact during the five-day week. On the weekends, she doesn't have any impact,'' he said.

MCG is in the midst of applying for a five-year continuation grant of the NHLBI study with the hope of following the children through adolescence.

Participants need to be followed for at least 10 more years into late adolescence, Dr. Strong said. At an early age, children naturally learn in the home environment. When they get into school, a variety of factors come into play. ''We've got to learn why they begin to model after their peers instead of just the family. We've got to learn what those attitudes are. Or, if a child learns it very well here in the home, is he likely to change them when he goes to school or keep on with the same basic principles? Nobody really had done that anywhere along the line with any behavior, not just cardiovascular disease,'' Dr. Strong said.

To date, the studies have enforced for Dr. Strong that genes are a significant factor when it comes to determining who gets cardiovascular disease. ''You are not doomed, but you have a higher risk,'' he said. But environment also has an impact.

''It's a combination of genes and environment which are the lethal types of problems,'' Dr. Strong said.

As a young man, he saw this principle at work when his father had his first coronary at age 36 and died at age 52. His father was a natural athlete, but also a heavy smoker. His father's parents both died of heart disease in their late 40s.

''Once I got interested in medicine, it was obvious to me that heart attacks didn't just come along and occur in a 52-year-old man.'' Dr. Strong wanted to intercede early on. Preventive cardiology affords that opportunity.

''That's dealing with kids, trying to get them to learn appropriate lifestyle, good behavior, good nutrition, good physical activity, to get them to learn how to cope with the various stressors in their lives,'' Dr. Strong said. ''If we can do that, then the impact is far, far beyond cardiology. The hope really is to deal with children to help them reach their fullest potential.''

—Toni Baker

A Bright Future

Dr. Frank A. Treiber is trouble-shooting.

He wants a sound method to identify young children likely to develop hypertension in adulthood.

He's gone to the Richmond County School System to identify 300 children. He's picking equal numbers of blacks and whites, all with family histories of hypertension who, based on a blood pressure screening, will be placed in a higher-risk or lower-risk group for developing high blood pressure.

Although all the children will have a family history of the disease, Dr. Treiber wants to know why some of the children will go on to develop the disease and others will not. And he wants to be able to predict those with the disease in their future.

''What are the differences between the two groups with respect to certain lifestyle habits that have been associated with hypertension risk in adults? Not a lot is known about this in children,'' said Dr. Treiber, child psychologist, assistant professor in the Medical College of Georgia Departments of Pediatrics and Psychiatry and Health Behavior and recipient of the $471,016 First Award grant from the National Heart, Lung and Blood Institute. ''Hopefully we will be able to identify some early antecedents, lifestyle behavior differences in children who are at varying risk for developing hypertension.

''Cardiovascular disease continues to be the number-one killer even with all the funding to try to identify precursors and to get earlier identification and more effective treatment regimens,'' Dr. Treiber said.

Anywhere from 15 percent to 22 percent of the American population has high blood pressure—one type of cardiovascular disease—and many may not be aware of their disease.

Blacks are two times more likely to develop the disease than whites. That black-white difference is a part of the total picture Dr. Treiber will explore.

He will follow for five years a group of 7- to 14-year-olds with family histories of hypertension. At this point, researchers are still in the process of identifying children for the study.

Once identified, parents will be interviewed about their children and the children will come in once a year for a series of tests.

''We will be exposing children to stressors that have been associated with blood pressure reactivity,'' Dr. Treiber said. These include treadmill exercise

Dr. Frank A. Treiber

and challenging video games which mentally stress the child. Also, a cold pressor task will be used in which a bag of ice and water is placed on the head. Initially, this results in a decreased heart rate, but it also causes the body's vascular system to contract and the diastolic blood pressure to increase.

These cold pressor tasks, along with testing that has included video games, treadmill studies and stationary bicycling, have shown in previous studies that blacks exhibit greater blood pressure reactivity, which has been hypothesized as one factor responsible for the racial differences in incidence rates of hypertension, Dr. Treiber said.

Stress is a daily fact of life that comes in many packages, some positive and some negative, he said. And blood pressure changes constantly, responding to the day's various stressors.

In the controlled setting, doctors will expose these black and white children to various stressors, monitoring their response and following that response for five years.

"We will look at the stability and variability of blood pressure responses from year to year," Dr. Treiber said. "If somebody is a hot reactor right now, will they demonstrate similar responses five years from now? Say we have a 9-year-old who is a hot reactor, meaning his blood pressure goes way up compared with other children his age when we put him on the treadmill or give him the video game task. When we test him again at age 18, is he still a hot reactor? And how does that associate with what his resting blood pressure has done over time?

"We will have some of the children during the study who will become borderline hypertensive," he said. Others won't have any significant change in pressure.

"What are the differences in these children and how are they associated with reactivity to stress over the years?" he said. "What we are thinking we will find is that children who develop borderline hypertension will have been hot reactors in the earlier tests and continue to be more reactive to stress. They are going to show consistently greater blood pressure responses.

"What we continually find is that blacks are showing excessive blood pressure reactivity to stress. It's not that whites don't. Everybody goes up, but blacks are exaggerated.

"There is some indication that there are genetic predisposition differences between blacks and whites, some biological differences between the way blacks and whites respond to stressors," he said. "It looks as though the underlying hemodynamic mechanisms that regulate blood pressure responses are different between blacks and whites." Researchers will try to determine why this black-white difference in reactivity to stress exists.

MCG is one of the first centers to study the underlying regulators that cause the blood pressure to change in all children. These issues—such as how much blood pressure varies over time and how useful reactivity tests such as the cold pressor task are—never have been addressed over a period of time.

Dr. Treiber is asking because he wants answers to questions such as whether the reactivity tasks hold up over time as good predictors of children who are at increased risk of developing hypertension.

"When we test the children, will we find a group that is really reactive to stress?" he said. "Five years later, are they more likely to develop hypertension than all these other kids who are less reactive?"

He also wants to know how these children cope with frustration and anger. "Do they overtly express it? Are they yellers and screamers and cussers and throwers of dishes and slammers of doors? Or are they suppressors? Do they hold it all inside? With adults, ineffective management of anger has been related to increased blood pressure," Dr. Treiber said.

Factors such as the child's level of physical activity and his diet also will be explored in the study. Cholesterol studies will be done since there are indications that high cholesterol levels are related to greater reactivity to stressors.

The idea is that a child's response to all these stressors, as well as his levels of physical activity, nutrient intake and coping styles, may prove to be the detectors needed to determine which children will go on to develop high blood pressure. Early identification means early intervention.

"We can't do anything about genetic predisposition," Dr. Treiber said. "But we can look at your environment and maybe do something about that." ■

—Toni Baker

"I'd like to begin," Medical College of Georgia School of Medicine freshman Karen Czuba said, "by asking everybody what they had for dinner last night."

The Girls' Club of Augusta, where Ms. Czuba was delivering a nutrition lecture, suddenly seemed transformed into a courtroom. The teen-age girls attending the lecture giggled, blushed, cast downward stares and looked like they were about to confess to crimes.

"Pizza," one teen mumbled into her hand.

"Pardon?" Ms. Czuba said. "Pizza?"

The teen rolled her eyes and nodded. "Pizza."

The other answers were equally incriminating. Cheeseburgers and fries seemed to have been the order of the day. In fact, if this group was any indication, fast-food restaurants are doing quite a bang-up business.

The group's junk-food mania was further evidenced by the potato chips munched and the soft drinks sipped during the lecture.

During the next hour, the teens were told that junk food is okay in moderation but that a well-balanced diet is essential to good health. The message was solemn but the presentation was not. Ms. Czuba enlisted the help of cartoon cat Garfield via a slide projector to soft-sell the importance of good nutrition. She also pointed out how advertisements can mask the empty-calorie aspect of their products or entice the public with ineffective fad diets.

By the end of the lecture, Ms. Czuba and the teens had giggled their way through confessions of dietary transgressions and ideas about how to mend their ways.

"Just do your best," was Ms. Czuba's parting advice. "If you're happy with yourself, that's what counts."

Sure, you've heard it all before: smoking and drug abuse will kill you, exercise will add quality and quantity to your life, and proper nutrition is a must. But don't confuse Doctors Ought to Care (DOC) or Students for Community Involvement (SCI) with other groups that tout these messages. These organizations spread the word of healthy living in decidedly unique ways.

DOC, the organization Ms. Czuba represented during her nutrition presentation at the Girls' Club, consists of health care professionals and medical students nationwide. It was founded in 1978 to target those most vulnerable to vices: kids. But its members accepted two premises from the outset: that kids don't care to be preached at and that they are too convinced of their immortality to concern themselves with potential future health problems resulting from their current lifestyles.

So kids turn deaf ears to threats of lung cancer and heart disease. What do they care about?

"Yellow teeth and zoo breath," said Dr. John William (Rick) Richards Jr., an associate professor of family medicine at the Medical College of Georgia. Dr. Richards is the faculty adviser of the MCG chapter of DOC, which was founded in 1983, and president of the national group.

"Kids aren't worried about dying in

Class Acts

50 years," Dr. Richards said. "They are worried about how their breath smells right now. If you talk about how (unhealthy habits) affect them now, you have a much better chance of getting their attention."

The DOC chapter's members consist of 90 students and several residents and faculty.

Group members regularly trek to local elementary and high school classrooms (mostly those in Richmond and Columbia county schools) and other community organizations to discuss such intricacies as zoo breath and other drawbacks associated with smoking, substance abuse, poor nutrition and sexual irresponsibility. Dr. Richards designed a program in 1978 to train the speakers.

"Since that time, the project has evolved through trial and error," he said. "We use a discussion format and slides. The presentations revolve around decision-making skills and ridiculing false images presented by TV, movies and advertising."

Those images include tobacco and alcohol companies' advertisements designed to glamorize and sanitize their products. DOC tears to shreds the wholesome, healthy models the advertisements portray. For instance, one DOC slide replaces a tobacco company's rugged, robust Marlboro man with the sickly, feeble Barfboro man. The latter, DOC members tell the schoolchildren, is a more accurate image of a smoker.

To further discredit advertisers' portrayals of smokers, DOC hosts a yearly Emphysema Slims tennis tournamant. The tournament provides a platform for the group's pro-health message and spoofs tobacco company-sponsored athletic events. Other DOC projects include blood drives and clothes drives for the homeless.

DOC speakers almost invariably elicit rousing responses from the youths. "The most common comment we get from teachers is the enthusiasm," Dr. Richards said. "We make it fun."

SCI uses a similar format. The group consists mostly of freshman and sophomore MCG medical students. SCI was founded in 1979 by Dr. William B. Strong, director of the Georgia Prevention Institute, Charbonnier professor of pediatrics and chief of the section of pediatric cardiology at MCG, and Dr. Maurice Levy, an MCG professor of pediatrics.

MCG sponsors 12 lectures about preventive cardiology September through March for SCI members. The lectures, taught mostly by MCG faculty, provide information about such issues as smoking, exercise and nutrition.

The students also are trained to convey the same information to children. Then, in April and May, they visit sixth-grade classrooms in Richmond County and lecture the children about the subjects. Each student lectures at least three classes and works with the students' teachers to reinforce the messages throughout the year.

"We felt that the best way to teach medical students was to have them do the teaching," Dr. Strong said. "That really formed the core of the program."

The program began as one of seven national preventive cardiology projects funded by the National Institutes of Health (NIH) in 1979. NIH gave MCG $385,000 for five years to implement a preventive cardiology project. Drs. Strong and Levy then formed SCI, which since has been duplicated by seven other medical schools. The program now is an elective for medical students.

"I would say it's the most popular elective course in terms of the number of students who participate," said Dr. Levy. About 50 to 100 participate each year. Since SCI's inception, some 500 students have spread their health messages to more than 18,000 sixth-graders.

Like DOC, SCI stresses the children's participation.

"The main thing is to get the children involved by asking questions," Dr. Strong said. "The medical students have done a very good job of developing rapport with the kids."

The program has been so successful that Drs. Strong and Levy hope eventually to offer the lectures to several grades and to have students from MCG's other four schools participate. Everyone benefits from SCI, they said.

"Not only does this help the children, but it gives medical students a chance for community involvement," Dr. Strong said. "They have an obligation to the community above and beyond their professional activities. These students are very altruistic and oriented toward helping others. This is an opportunity for them to express that. They're a neat bunch of young people."

Life in the country—the simplicity, the fresh air, the verdant scenery—can seem awfully enticing.

But the reality of country life for many rural Georgians isn't quite so appealing. Poverty tends to dim the glow of even the most idyllic settings.

And whereas country dwellers are free of the bustle of cities, they also often must forego such amenities as quick and easy access to medical care.

Students at the Medical College of

Georgia don't think they should have to. And they're doing something about it.

Dr. Richard M. Martin, associate professor of humanities at MCG, co-founded the Georgia Student Health Association (GSHA) in 1976 and is currently chairman of the board. The group, which consists mostly of MCG students, has but one goal: to improve health care for rural Georgians.

The students accomplish this in two ways: by offering health fairs in rural, medically underserved Georgia counties and by teaching the residents to help themselves.

"Our primary object is to help local people discover their own resources and learn to obtain the health care they need," Dr. Martin said.

Participating students go to these sites the summer before their sophomore year at MCG. They are paid small salaries and the host community provides lodging, usually in the homes of local families, and meals, usually hosted by families, churches and civic groups.

Also provided is a health fair site. The students, supervised by physicians, run the fair. They provide physical examinations which include such things as eye exams, hearing tests, Pap smears and laboratory screenings for nutritional problems.

"It's surprising how many nutritional problems people have in rural Georgia," Dr. Martin said.

GSHA participants also provide health screenings at community nursing homes, work with community leaders to ensure continued health care and offer educational booths at the fairs, informing community residents about such issues as AIDS and smoking. "The students really run the thing," Dr. Martin said. "They organize the community projects and do a very good job."

The results of their efforts have been impressive—even potentially life-saving. "It's always exciting for students to discover a problem and help save somebody's life," Dr. Martin said.

The students' enthusiasm is evidenced in comments Dr. Martin compiles about their experiences.

"There is not a job or program anywhere that will give a young medical student more opportunity for personal and professional growth—and on top of everything else, it's just plain fun," wrote MCG medical student John Doster, a 1988 participant. "I can't recommend it more highly to any community in need of such a service or to any student who's interested in getting some hands-on experience."

Another 1988 participant, also an MCG medical student, lauded the back-to-basics aspect of the program. "After the book work, the grind and frustration of the first year of medical school, this summer offered me a chance to be reminded of what the practice of medicine is about," wrote Lisa Hospodar. "Above all, it gave a needed spirit of renewal to take into the second year."

1987 participant Robin Collins noted that the experience is as meaningful for the community as it is for the students. "The (patients) were all so grateful and appreciative; they considered us 'real doctors' and made me feel that I was doing some good."

Last summer's participants were divided into two teams. One set up shop in Lincoln County, the other in Taliaferro County. The participants, including three students from the Southern School of Optometry in Memphis, saw 573 patients in Lincoln and 164 patients in Taliaferro.

"They didn't see as many people as some of our earlier teams did, but they only stayed for two weeks," Dr. Martin said.

Previous teams stayed longer because of more plentiful funds. The group received state and federal funds the first two years of its existence but must now rely on private funding. The Chattanooga, Tenn.-based Lyndhurst Foundation has been the group's chief financial supporter for several years.

As is true of almost every other aspect of the program, students are primarily responsible for obtaining funding.

"We've wanted to keep it student-run," Dr. Martin said. "We simply will close shop if we have to have it any other way."

—Christine Hurley Deriso

Dr. Richard Martin (seated) discusses program.

That's What Friends Are For

In March 1988, Scott Collins* was admitted to Augusta's St. Joseph Hospital because he was having difficulty breathing. Within a few days, his children were told that he would likely die within an hour.

Mr. Collins had Pneumocystis Carinii pneumonia , a condition usually associated with AIDS.

Within 24 hours, Mr. Collins' condition began to improve. Hope, which had all but disappeared, began to return. Mr. Collins resumed a productive life and learned to fight the disease that had almost beat him.

"The real battle for me was to keep a positive attitude," Mr. Collins said.

While in the hospital the first time, Mr. Collins was told about a local group of volunteers who had formed an organization dedicated to helping people with acquired immune deficiency syndrome.

"I was looking for a support group more than anything else at first," Mr. Collins said, "but as I got better, I was looking for a place where I could help other people who were going through the same thing."

* Not his real name.

At that time, AIDS Crisis Volunteers of Augusta (ACVA) was a fledgling organization started by a group of people who knew that the AIDS problem was likely to intensify rather than go away.

Brad Littleton, a nurse anesthetist at the Medical College of Georgia, is a founding member and president of ACVA.

"We had begun to see more and more HIV (human immunodeficiency virus) patients and I gained an interest in the problem," Mr. Littleton said. "When I heard that a group of local people were starting a support group, I contacted the infectious disease section to compile some information about the problem. I went to the first meeting expecting to share some statistical information with the group and came away from it as president."

Since that first meeting, ACVA has grown and changed to meet the needs of the HIV community in the Augusta area. ACVA now has 55 voting members and over 100 volunteers. Many office holders are on staff at local hospitals including the Veterans Administration Medical Center, Eisenhower Army Medical Center and St. Joseph Hospital.

ACVA offers a variety of support services. When first starting out, the group listed support for people with AIDS as one of its three main priorities. But an early attempt to start an organized support group failed.

"It was difficult getting people with AIDS interested because of the stigma associated with the disease in a small city," Mr. Littleton said.

After this early disappointment, the board of directors for ACVA scheduled a series of informal drop-in receptions for members of the group, people with AIDS and their families.

Eventually, the volunteers dropped out and the meetings were left to those with AIDS and one professionally trained leader.

Originally, the support group met once a month. In August, members of the group approached the board of directors and requested more meetings. Since then, ACVA support group meetings have increased to twice monthly.

With the support group running smoothly, it became obvious that people with the disease were not the only ones who needed support. In October, two new support groups were formed, one for the families of people with the disease and the other for volunteers and professionals who work with people with AIDS.

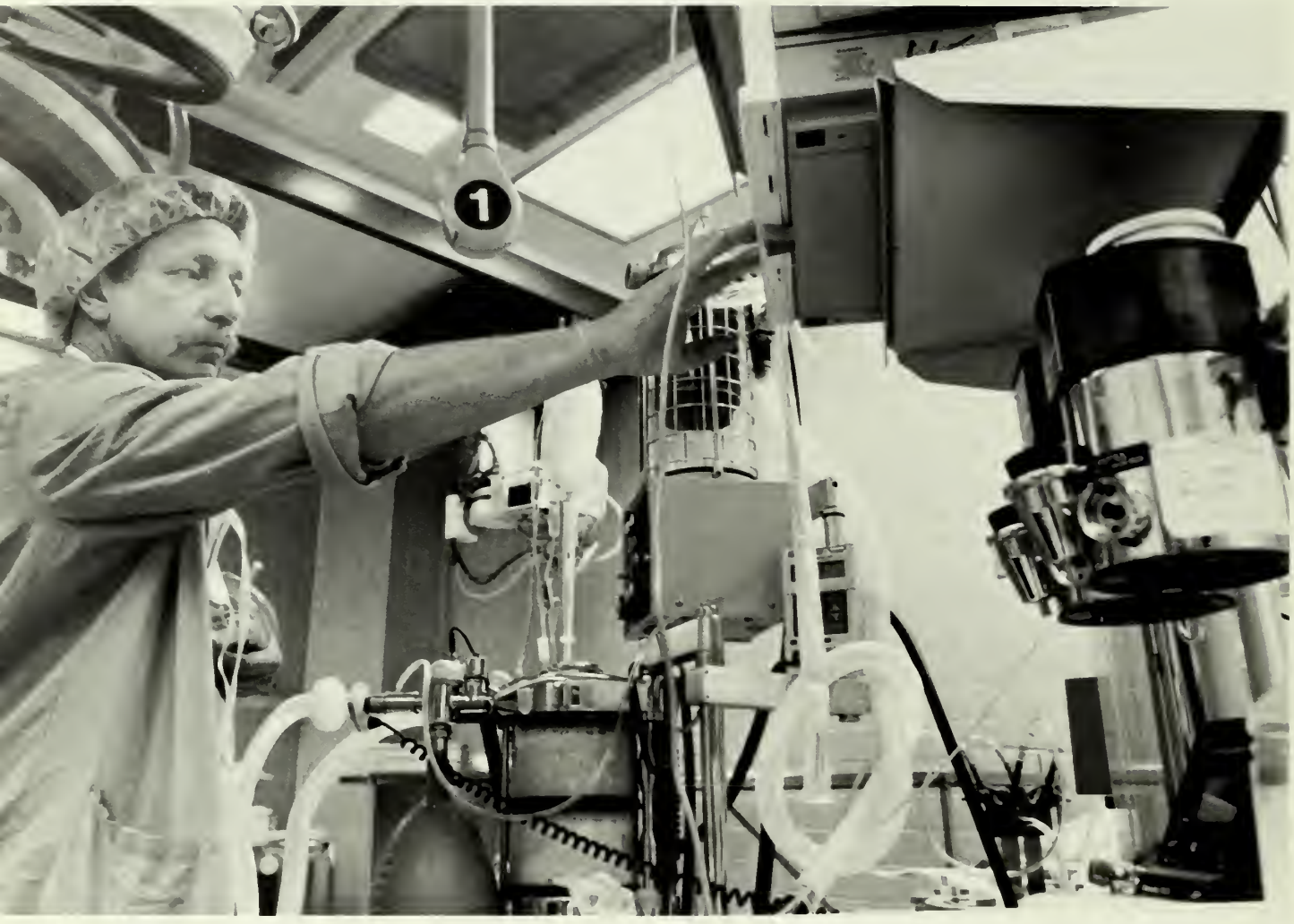
"People who actually have the disease are not the only ones who suffer from AIDS," Mr. Littleton said. "Everyone who is around AIDS suffers in one way or another."

Dr. Beth Goldstein, an MCG third-year resident, is quality assurance director for ACVA. She said AIDS has been difficult even for the medical community to deal with.

"Generally the care of AIDS patients is good," Dr. Goldstein said. "But there are some physicians who still refuse to treat HIV patients, or will not treat patients unless they undergo an HIV test."

This fear and confusion is what originally interested Dr. Goldstein in helping people with AIDS. She recalls instances in which patients were treated unfairly because of the nature of their disease.

"The key features of ACVA that I feel are most important for physicians to know about (are that) if they are doing HIV testing and do not feel comfortable counsel-



Brad Littleton

ing patients, ACVA will do it. If they have an HIV patient who needs support, ACVA will do it. If a family is having a hard time coping with AIDS, ACVA can help.''

ACVA also has educational services.

Dr. Julia Crowley, MCG professor of medical technology and educational coordinator for ACVA, became involved with the group in late 1988. She realized a need to educate the public about the disease and decided ACVA was the best way to do that.

By the time Dr. Crowley joined, an AIDS hotline was already in place and a speakers' bureau had been formed to address local groups interested in learning more about the disease.

Most of the more than 100 calls received on the hotline are from people wanting information about the symptoms of the disease and testing procedures.

''Our hotline volunteers have got to know the basic facts about the disease,'' Dr. Crowley said. ''They have also got to be able to handle high-anxiety situations. Many of these people are very frightened by the time they call. Our volunteers have got to be truthful and informative, but at the same time, they may need to calm these people down.''

Dr. Crowley said there is a fine line between giving out the facts on AIDS and offering medical advice. Volunteers must be carefully taught not to cross that line, she said.

''We have also got to be able to speak candidly and be unbiased about some extremely sensitive issues,'' she said.

Many who call are unaware of the facts about the disease because they have never heard them in language they can understand, according to Dr. Crowley. One of the tasks of the volunteers is to adapt to the educational background of the caller.

''Volunteers must also remember to maintain the strictest confidentiality and know certain things about the Social Security system and other benefits a person with the disease may need to know,'' Dr. Crowley said.

Hotline volunteers are required to attend a two-day workshop. During the sessions, they are taught all of these things. All reference materials used during the training sessions are available at the ACVA office.

During the training, the volunteers are addressed by social service workers, doctors, nurses, lawyers and psychiatrists. Dr. Crowley said there is a lot to learn in two days, and access to the material discussed is available if a volunteer has a question. Hotline personnel also meet once a month to discuss any problems they may be having or any new information they may need to know.

Another educational aspect of ACVA is the ''buddy program,'' in which people with AIDS are assigned a volunteer. That volunteer periodically calls and drops in on the

person with AIDS for a visit. Volunteers may also do some light housework or take their buddy out for dinner, a movie or a trip to the mall.

Dr. Crowley hopes this program will not only provide a morale boost for the participants, but also tighten the bond between volunteer and client.

ACVA's future goals include financial help for people with AIDS and even housing for those with nowhere else to go.

Dr. Julia Crowley

Dr. Beth Goldstein

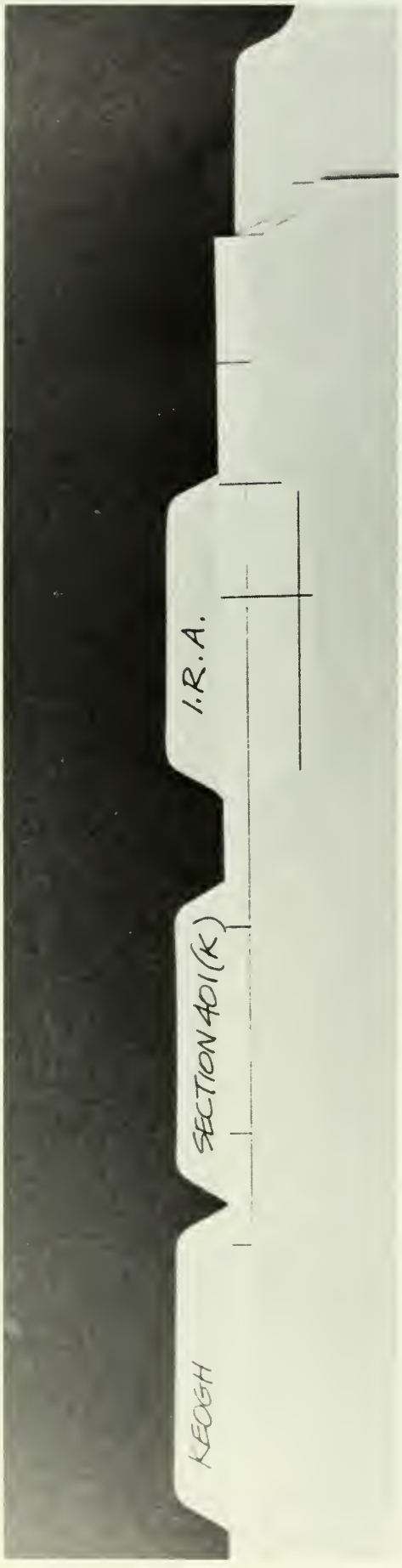
Like most charitable organizations, however, funding is a major problem. Some relief came in the form of a United Way grant recently, but there will never be too much money, according to Mr. Littleton.

The number of AIDS cases in the 10th Congressional District is growing faster than that of any other area of the state. In the first eight months of 1988, the number of cases increased by 140 percent. With numbers like that, the volunteers of ACVA admit they have a lot of work ahead.

"We are probably the only group incorporated by the state of Georgia that wants to see ourselves go out of business," Mr. Littleton said. "But that isn't likely to happen any time soon." ■

—David Waller

Editor's note: AIDS did eventually beat Mr. Collins; he died Feb. 17.



Planned Giving

As you may know, we Americans are saving money at a perilously low rate. According to recent data, the U.S. savings rate averages only 4 percent of total family income. The savings and investments of our society help fuel the capital growth of our nation. In recent years, much of this needed capital investment has come from foreign sources.

The federal government has provided certain mechanisms which make savings plans more attractive. Corporate savings plans called Section 401(K) plans allow employees to accumulate savings tax-deferred. In 1989, the law allows a qualified contribution up to $7,629. This set aside is excluded from income subject to tax, thereby reducing one's annual tax bill.

Self-employed individuals can utilize Keogh plans to accumulate retirement income. Generally, this program allows a tax-deductible contribution up to 25 percent of your net income, to a maximum of $30,000. There are catch-up provisions which allow participants to set aside more than the maximum in any one year. I am sure many alumni of the Medical College of Georgia participate in such arrangements.

Another very common program is the Individual Retirement Account (IRA). The current provisions of the law allow an annual $2,000 tax-deductible contribution with income accruing free of tax until distributions begin. The 1986 tax reform allows married workers covered by company plans to full deductions on the first $40,000 of combined income. There is a loss of 20 percent of the deduction on incomes above $40,000.

Another major area for tax-encouraged savings involves charitable life income plans. While there are a number of variations on the same basic theme, each involves a transfer of funds to a trustee in exchange for a lifetime income. Upon the participant's death, the assets go to a qualified institution like MCG.

One such method is a deferred payment gift annuity. To illustrate, assume a 45-year-old is engaged in a successful practice. He makes the maximum contribution to a Keogh retirement plan, he has met IRA limitations, yet still wishes to set aside additional funds in a tax incentive situation. Let's also assume this individual is married, wishes to adequately provide for his spouse and wants to make a significant capital gift to the Medical College.

The couple creates a deferred payment gift annuity placing $5,000 a year into a series of joint and survivor gift annuities, scheduling income payments to begin in 20 years. While the plan does not allow a fully tax-deductible contribution each year, it does not fully tax the distributions either. During the 20-year payment period, the deductible amount averages 68 percent of the contribution. Based on current income rates, the annual income payment at age 65 would be $10,530 or 10.53 percent of the contributions of $100,000. The effective payment rate is 13 percent when considering the tax savings on the annual contributions. MCG would receive the remaining assets upon the survivor's death.

I think the plan makes a lot of sense for those who wish to accumulate savings and make a significant capital gift to the Medical College of Georgia. For further information on this topic or other life-income gifts to MCG, contact me, Bruce Howerton, at (404) 721-4001.

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